Supreme Court, U.S.
FILED

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NO. 03-

IN THE

SUPREME COURT OF THE UNITED STATES

BRUCE A. WALLACE

Petitioner,

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY

Repondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THEUNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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21 pp

QUESTION PRESENTED

Should this Court resolve the conflicting authority regarding whether an insurance company is acting as a fiduciary, pursuant to 29 USC § 1002(21)(A)(1), when performing duties as the final reviewer of denied benefits claims pursuant to 29 U.S.C. § 1133?

PARTIES TO THE PROCEEDINGS

Petitioner is Bruce A. Wallace. He is plaintiff in the District Court and appellant in the Court of Appeals.

Respondent is Reliance Standard Life Insurance Company (hereinafter "Reliance"). Reliance is defendant in the District Court and appellee in the Court of Appeals.

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PETITION FOR WRIT OF CERTIORARI

Petitioner Bruce A. Wallace respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Seventh Circuit entered in this proceeding on February 4, 2003.

OPINIONS BELOW

The decision of the Court of Appeals is reported at 318 F.3d 723. The ruling of the district court is unreported.

JURISDICTION

The jurisdiction of this Court is invoked under 28 USC § 1254(1). The judgment of the Court of Appeals was entered on February 4, 2003.

Because this matter presents questions of federal law arising under ERISA, 29 U.S.C. §§ 1001, *et. seq.*, the United States District Court for the Western District of Wisconsin had original jurisdiction over this case pursuant to 28 U.S.C. § 1331. As an ERISA claim, jurisdiction is specifically conferred by 29 U.S.C. § 1132(e)(1). Bruce Wallace timely filed an appeal of the District Court's judgment dismissing the action, giving the United States 7th Circuit Court of Appeals appellate jurisdiction over the matter pursuant to 28 U.S.C. § 1291.

RULES INVOLVED

This petition involves review of provisions of the Employee Retirement Income Securities Act of 1974, 29 U.S.C. §§ 1001, *et. seq.* (ERISA).

1. 29 U.S.C. § 1002 (21)(A), which states

> Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such

plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.

2. 29 USC § 1104(a), which reads

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and--

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

3. 29 USC § 1133, which reads

> In accordance with regulations of the Secretary, every employee benefit plan shall—
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

4. United States Department of Labor regulation 29 C.F.R. § 2560.503-1(h)(1), which reads

> (h) Appeal of adverse benefit determination
>
> (1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

STATEMENT OF THE CASE

Petitioner, Bruce Wallace, has a long-standing history of Type II diabetes, dating back to the late 1970's. (R.7, Defendant's Motion for Summary Judgment, pp. RSL0145-0147, Apx. 124-126). This condition progressively worsened over time, and in September of 1998 he was forced to quit working at his position as Midwest Regional Sales Manager with Fujinon, Inc., due to his signs of kidney failure, diagnosed end stage renal disease, secondary to hypertension and diabetes. (R.7, Defendant's Motion for Summary Judgment, pp. RSL 0151-153, Apx. 130-132). At the time he stopped working at

Fujinon, he filed a claim for long-term disability benefits under his Group Long-Term Disability Plan through Fujinon. (R.7, Defendant's Motion for Summary Judgment, p. RSL0387, Apx. 170). Fujinon's Employee Benefit Plan is self-funded and governed by ERISA. The Plan bought a long-term disability policy from Reliance Standard Life Insurance Company, who pays claims out of its own coffers and also decides claimant eligibility under the terms of its policy. (R.3, Answer, p.1, Apx. 33) Reliance approved Bruce Wallace's claim for long-term disability benefits on March 17, 1999. (R.7, Defendant's Motion for Summary Judgment, p. RSL0348, Apx. 151).

On August 1, 1999, Bruce Wallace underwent a kidney transplant. (R.7, Defendant's Motion for Summary Judgment, p. RSL0151, Apx. 130). While the transplant itself has been successful overall, Bruce Wallace's subsequent medical regimen has had complications. (R.7, Defendant's Motion for Summary Judgment, p. RSL0134, Apx. 113), including a thoracic vertebral body compression fracture and other various ailments such as continued problems with his diabetes, osteoporosis, anemia of chronic disease, chronic venous stasis and lower extremity edema. (R.7, Defendant's Motion for Summary Judgment, p. RSL0085, Apx. 91). Mr. Wallace was taking as many as 20 prescribed medications to deal with these medical conditions. (R.7, Defendant's Motion for Summary Judgment, p. RSL0112, Apx. 104)

In June of 2000, Reliance asked two of Bruce Wallace's treating physicians, Dr. Robert Turner and Dr. Bryan Becker, respectively, to fill out Physical Capability Assessments (PCA's) regarding his medical conditions as it related to his work abilities. (R.7, Defendant's Motion for Summary Judgment, p. RSL0159, Apx. 142; RSL0129, Apx. 138). Both doctors completed the forms and indicated that Mr. Wallace could exert himself on a light level of work duty, and could stand, sit, and walk on an occasional basis (33% of an eight hour workday) only. (R.7, Defendant's Motion for Summary Judgment, pp. RSL0108-109, Apx. 102-103; RSL0130-131, Apx. 110-111).

Reliance denied Mr. Wallace's continued receipt of benefits via a July 7, 2000 letter, citing the PCA's as well as the lack of

objective medical evidence supporting his continued total disability. (R.7, Defendant's Motion for Summary Judgment, pp. RSL0018-20, Apx. 61-62).

Mr. Wallace retained an attorney and appealed Reliance's adverse benefit claim decision. The appeal was to Reliance itself. (R.7, Defendant's Motion for Summary Judgment, pp. RSL0047-53, Apx. 64-70). In support of his appeal, Mr. Wallace submitted a report, dated September 5, 2000, from his primary treating physician, Dr. Turner, explaining that "due to his renal transplant, multiple medications, diabetes, chronic venous stasis, vertebral body compression fractures and peripheral neuropathy, he is unable to maintain hours that would allow him to participate in employment." (Id.).

Reliance conducted a review of Wallace's appeal, but again denied benefits via a letter dated January 9, 2001, citing a lack of medical evidence to support Dr. Turner's September 5, 2000 report. (R.7, Defendant's Motion for Summary Judgment, pp. RSL0047-53, Apx. 64-70).

On December 28, 2001, Bruce Wallace filed a lawsuit in the United States District Court for the Western District of Wisconsin under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§1001 *et. seq.* seeking long-term benefits as well as equitable relief for Reliance's breach of its fiduciary duties in the handling of its denial. Wallace specifically alleged that Reliance was a fiduciary of the ERISA pursuant to 29 U.S.C. 1002(21)(A), due to its authority to review, approve, and/or deny benefits claims. Moreover, throughout this case, it is, and was, Wallace's contention that Reliance breached its fiduciary duties by denying Wallace's claim for benefits without giving proper weight and attention to Dr. Turner's September 5, 2000 report. Specifically, as a fiduciary, Reliance should not have summarily discredited the concise statement of disability by Dr. Turner, a board-certified internist, without having done sufficient investigation into his statement and without any objective medical evidence refuting his statements.

Reliance conceded that it was a fiduciary pursuant to 29 U.S.C. 1002(21)(A) but disputed Wallace's allegation that any

fiduciary duties were breached in its decision to deny benefits. On March 29, 2002, Reliance moved for summary judgment, arguing that it was entitled to judgment as a matter of law, that Bruce Wallace was not "Totally Disabled" as defined in the Reliance Plan, and that Reliance did not act improperly in denying Bruce Wallace's benefits. On June 21, 2002, the District Court, in a memoranda opinion authored by the Hon. Barbara B. Crabb, District Judge, granted Reliance's motion and entered an Order dismissing Bruce Wallace's claims. Bruce Wallace appealed Judge Crabb's decision to the United States Court of Appeals for the 7th Circuit.

RULING ON APPEAL

On Wallace's appeal, the 7th Circuit affirmed the decision by District Court by holding that Reliance was not a "fiduciary" as alleged by Wallace and therefore breached no duty to Bruce Wallace in its handling of his claim for benefits.

The 7th Circuit recognized that a genuine fiduciary would be compelled to act as Bruce Wallace's advocate, but relied on *Pegram v. Herdrich*, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000) for the holding that, just as the HMO in *Pegram* did not assume any fiduciary status to the extent that it was implementing its contract of insurance sold to the ERISA plan, Reliance assumed no fiduciary status in implementing its disability-insurance policy sold to Wallace's employer. On this basis, the District Court's decision was affirmed.

REASONS FOR GRANTING THE WRIT

This case raises important issues surrounding the administration of, and disposition of, ERISA claims, and therefore is an issue of substantial national importance. This is especially so given the fact that the Seventh Circuit's holding, while logically aligned with this Court's reasoning in *Pegram*, contrasts with existing statutory authority and holdings in caselaw from other circuits. Because of this paradox, without this Court's clarification future ERISA litigation will necessarily be cast into a state of unpredictability and litigiousness.

This Court has specifically chided against such a result, as it has cautioned that we must be mindful of the "competing congressional purposes [behind ERISA], such as Congress' desire to offer employees enhanced protection for their benefits ... and ... its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *See Varity Corp. v. Howe*, 516 U.S. 489, 497, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996).

A. The Seventh Circuit's Holding Is Consistent With *Pegram*

As this Court elaborated in *Pegram*, the threshold question for any breach of fiduciary claim under ERISA is whether the entity providing services under the ERISA plan was performing a fiduciary function when taking the action that is the subject of the Complaint. *See Pegram, Id.* at 218, 120 S.Ct. at 2148. Therefore, in *Pegram*, this Court necessarily confronted the question of whether, when an ERISA Plan purchases an insurance policy, the secondary policy carrier is a fiduciary per se. *See Id.*

An important part of the *Pegram* analysis focused on the nature of the relationship between the HMO and the ERISA plan. Clearly, the terms of the HMO's contract regarding treatment decisions was not, itself, the ERISA Plan, but rather was a contract *sold to* a plan. Therefore, when a doctor is making decisions under the contract to the employer's ERISA plan, that doctor is not acting as a fiduciary because he or she is simply implementing the language and terms of the contract to the plan, as the language of that contract may hold.

Likewise, the Seventh Circuit notes in the present case that the disability insurance benefit to an employee such as Bruce Wallace is the insurance contract, itself, through Reliance. Therefore, decisions made by Reliance in interpreting its contract in response to claims for benefits under its contract are no different than the doctor in *Pegram* interpreting and implementing the terms of its contract when making eligibility and treatment decisions. (App-3).

Moreover, as Judge Easterbrook points out in the present case, the symmetry is consistent with *Rush Prudential HMO, Inc. v. Moran*,

536 U.S. 355, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002), where this Court notes that state regulation of an HMO providing benefits to participants in an ERISA plan is the regulation of an insurance contract rather than regulation of the ERISA plan.

In each instance, no fiduciary status is achieved because the function that is at issue is regarding the non-discretionary interpretation of an insurance contract sold to an ERISA plan rather than a discretionary function administrating the ERISA plan itself.

B. The Seventh Circuit's Holding Conflicts With Other Circuits

Consonant with the fiduciary reasoning of *Pegram*, the United States Circuit Courts have uniformly held that an entity can be and is an ERISA fiduciary toward those portions of an ERISA plan over which it performs duties falling within the statutory definition of an ERISA fiduciary under 29 U.S.C. § 1002(21)(A).

In contrast to the Seventh Circuit's decision in the present case, however, courts have routinely held than an entity is an ERISA fiduciary where, as Reliance did in the present case, the entity has the ultimate authority to review and decide disputes over denied claims for benefits. *See, e.g., Baker v. Big Star Division of the Grand Union Company*, 893 F.2d 288 (11th Cir. 1990) (entity with authority to review claim denials is ERISA fiduciary); *Aetna Life Insurance Company v. Bayona*, 223 F.3d 1030 (9th Cir. 2000) (insurance company with final decision-making authority to approve or deny claims is fiduciary pursuant to 29 U.S.C. 1002(21)(A)(iii)); *Molasky v. Principal Mutual Life Insurance Company*, 149 F.3d 881 (8th Cir. 1998) (insurance company assumes fiduciary status by virtue of role in reviewing denied claims); *Ellington v. Metropolitan Life Insurance Company*, 696 F.Supp. 1237 (S.D. Ind. 1988) (insurance company is fiduciary to the extent that the claims procedure provides for its review and determination of denied claims).

Indeed, 29 U.S.C. § 1133 provides that any ERISA plan shall "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair *review by the appropriate named fiduciary* of the decision denying the claim." (emphasis

added). Further, the United States Department of Labor has published interpretive regulations in this context, providing that when an insurance company retains this claims review function for benefits under an ERISA plan, it is an ERISA fiduciary. *See* 29 C.F.R. § 2560.503-1(h)(1).

Pegram and its progeny has resulted in much comment regarding its role in the context of ERISA preemption, as it relates to the HMO setting. *See, e.g., Managed Care Liability For Breach of Fiduciary Duty After Pegram v. Herdrich: The End of ERISA Preemption For State Law Liability For Medical Care Decision Making*, 53 Fla. L. Rev. 1 (2001); *Distinguishing Between Coverage and Treatment Decisions Under ERISA Health Plans: What's Left of ERISA Preemption?*, 49 Buff. L. Rev. 1219 (2001). The Seventh Circuit's decision in this matter has already resulted in articles commenting on the fact that an insurance company is not an ERISA fiduciary. *See, e.g., Insurance Company Is Not a Fiduciary*, 20 No. 8 Emp. Alert. 11 (2003). Likewise, if the Seventh Circuit is correct in this matter there will undoubtedly be further comment and caselaw regarding ERISA preemption as it relates to insurance company claims administrators. Any such comment or holding has the dubious task of squaring with this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987) which clearly held that state-law bad faith or contract claims are preempted by ERISA.

Moreover, if an insurance company retaining authority to review denied claims, with a statutory duty to do so in a "full and fair" manner, is not a fiduciary and therefore not subject to ERISA liability, yet not amenable to any state common law liability pursuant to *Pilot Life,* the question that necessary follows is: does an insurance company conducting a claims review pursuant to 29 U.S.C. § 1133 face any liability whatsoever in its performance of these statutory duties?

This is a question that Bruce Wallace respectfully requests that this Court address.

CONCLUSION

For the reasons stated above, Petitioner respectfully requests that his Writ for Petition for Certiorari be granted.

Respectfully submitted.

Dated this 2d day of May, 2003

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In the
United States Court of Appeals
For the Seventh Circuit

No. 02-2934

BRUCE A. WALLACE,

Plaintiff-Appellant,

v.

RELIANCE STANDARD LIFE INSURANCE CO.,

Defendant-Appellee.

Appeal from the United States District Court
for the Western District of Wisconsin.
No. 01-C-714-C—**Barbara B. Crabb**, *Chief Judge*.

ARGUED JANUARY 14, 2003—DECIDED FEBRUARY 4, 2003

Before EASTERBROOK, RIPPLE, and ROVNER, *Circuit Judges*.

EASTERBROOK, *Circuit Judge*. After his diabetes led to renal failure, Bruce Wallace left his job as a manufacturer's sales representative and began receiving disability benefits under an insurance policy provided as a fringe benefit, and thus regulated by ERISA (the Employee Retirement Income Security Act). A successful kidney transplant ended Wallace's need for dialysis. When he did not return to work after recovering from the operation, Reliance Standard Life Insurance Co., which underwrote the disability insurance, cut off his benefits. Wallace sued under §502(a)(1)(B) of ERISA, 29 U.S.C. §1132(a)(1)(B). Be-

cause the policy does not confer interpretive discretion on Reliance, the district court made an independent decision about Wallace's eligibility. See *Herzberger v. Standard Insurance Co.*, 205 F.3d 327 (7th Cir. 2000). The judge concluded that ample medical evidence (including statements by physicians releasing Wallace for work) demonstrates that he is no longer disabled, and she entered summary judgment for Reliance. Because the district court made a *de novo* determination without objection from Reliance, this appeal is unaffected by the disagreement between this circuit and the ninth about the consequences of an insurer's or sponsor's financial interest. Compare *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 980-81 (7th Cir. 1999), with *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 828-29 (9th Cir. 2002), cert. granted, No. 02-469 (U.S. Jan. 10, 2003).

Wallace does not challenge the district judge's assessment of the medical evidence in the record. Instead he contends that Reliance was obliged to obtain additional medical evaluations, which would be submitted to an independent physician for assessment. Nothing in the policy, the employer's plan, or the summary plan description, requires Reliance to take such steps. Nonetheless, Wallace insists, Reliance was acting as his fiduciary, and as his fiduciary was obliged to seek out additional evidence supporting his claim, even if (especially if) the medical evidence he submitted was inadequate.

Yet why is Reliance a fiduciary when implementing a contract of insurance? It has promised a particular set of benefits, to be sure, and must act with care in fulfilling its promises, but it did not undertake to evaluate all claims with a thumb on the scale in the participant's favor. Indeed, a genuine fiduciary would go to bat for Wallace as an *advocate*; but this is not the role Reliance undertook to perform. *Pegram v. Herdrich*, 530 U.S. 211,

222-26, 231 (2000), holds that a health maintenance organization (another kind of medical insurer) is not an ERISA fiduciary to the extent that it makes decisions about the nature of the care required under the contract. Pre-*Pegram* opinions that loosely refer to medical insurers as fiduciaries are no longer authoritative (if they ever were; the passages in the cases to which Wallace points read like incautious dicta). Asked at oral argument what provision of ERISA turns an insurer into a fiduciary, Wallace relied entirely on 29 U.S.C. §1104. This section, however, specifies the duties of fiduciaries; it does not tell us who *is* a fiduciary. The "who" of the matter depends on 29 U.S.C. §1002(21)(A), which as the Court remarked in *Pegram* tells us that managers, administrators, and financial advisers of pension and welfare plans are fiduciaries. *Pegram* concluded that a contract of insurance sold *to* a plan is not itself "the plan," so that the HMO implementing its contract is not a fiduciary. Just so, one would suppose, with a disability-insurance carrier. Cf. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (state regulation of an HMO providing benefits to participants in a plan is regulation of insurance, not of the plan).

Now it is true, as we observed in *Hightshue v. AIG Life Insurance Co.*, 135 F.3d 1144, 1148 (7th Cir. 1998), that when an insurer permits an independent medical evaluator to make the coverage decision, it will be hard to show that the decision was influenced by a conflict of interest. Contentions that insurers deny claims to save money, and that judicial review should be more searching as a result even when the plan or policy confers interpretive discretion, are before the Supreme Court in *Nord*; no such issue is at stake here, because the district judge did not defer to Reliance's decision but made her own. *Hightshue* does not hold that an insurer *must* pay for independent medical evaluations or accept their conclu-

sions; it gives plans an option, not an obligation. Insurers remain free (as do judges) to resolve conflicts in the medical submissions. Their obligation is to evaluate claims competently and dispassionately—and even that duty plays a limited role when the judge proceeds *de novo*. No case of which we are aware holds that, when a plan participant's own doctors opine that he is again able to work, the insurer or plan administrator must refer the participant to additional physicians in quest of one who will find a disabling condition. Adding to the bureaucracy would augment administrative costs, which in the long run would reduce the net benefits that employees enjoy under the plan.

AFFIRMED

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

United States Court of Appeals

For the Seventh Circuit
Chicago, Illinois 60604

JUDGMENT - WITH ORAL ARGUMENT

Date: February 4, 2003

BEFORE: Honorable FRANK H. EASTERBROOK,
Circuit Judge
Honorable KENNETH F. RIPPLE,
Circuit Judge
Honorable ILANA DIAMOND ROVNER,
Circuit Judge

No. 02-2934

BRUCE A. WALLACE,
Plaintiff - Appellant

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY,
Defendant - Appellee

Appeal from the United States District Court
for the
Western District of Wisconsin
No. 01 C 714, Barbara B. Crabb, Chief Judge

The judgment of the District Court is AFFIRMED, with costs, in accordance with the decision of this court entered on this date.

(1061-110393)

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

BRUCE A. WALLACE,

Plaintiff,

JUDGMENT IN A CIVIL CASE

vs.,

Case No.: 01-C-714-C

RELIANCE STANDARD LIFE INSURANCE COMPANY

Defendant.

This action came for consideration before the court with U.S. DISTRICT JUDGE BARBARA B. CRABB presiding. The issues have been considered and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

that the motion for summary judgment filed by defendant Reliance Standard Life Insurance Company is GRANTED and this case is closed.

/s/_____ Dated: June 24, 2002
Joseph W. Skupniewitz, Clerk of Court

Copies mailed to Attys
Krueger & Munson on 6/24/02
Joseph W. Skupniewitz, Clerk
U.S. District Court
Western District of Wisconsin

By:/s/_____
Deputy Clerk